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The document mentioned above has been reviewed and accepted by the student's advisor, on behalf of the advisory committee, and by the Assistant Dean for MSN and DNP Studies, on behalf of the program; we verify that this is the final, approved version of the student's DNP Project including all changes required by the advisory committee. The undersigned agree to abide by the statements above.

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Barriers to Screening for Intimate Partner Violence Among APRNs in Kentucky

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College of Nursing

Spring 2019

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Dedication

This capstone project is dedicated to my family, whose love, support, and encouragement made this achievement a reality. To my dear husband, Kevin, who encouraged me, listened to my daily struggles and celebrations, and continuously helped me to remain balanced, thank you and I love you with all my heart. To my parents, Rusty and Greta Strait and Jeff and Angela Marshall, who have always supported my dreams, I could not have completed this achievement without you all.

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Abstract

Purpose: Intimate partner violence (IPV) occurs in at least one in every four females and one in nine men across the United States (Smith et al., 2017). While the prevalence of IPV is considerably high, the screening rates for IPV in primary care specifically average less than 12% (United States Preventative Services Task Force, 2013). *Methods:* In order to identify how to overcome the barriers to screening including time, knowledge of IPV, access to community resources, gender identity/sexual orientation, accuracy and availability of screening tools, and reimbursement for advanced practice nurses in Kentucky, a survey was sent to a state organization for advanced practice nurses with 43 responses. *Results:* The results indicated that time was the most significant barrier while sexual orientation/gender identity was the least identified barrier to screening. After receiving education on how to overcome these barriers, providers identified that they felt more comfortable overcoming the barriers and 50% of respondents would begin to screen for IPV in their current practice. *Implications:* Education on IPV is needed for advanced practice nurses in Kentucky in order to increase screening rates of IPV.

Introduction

Across the United States, at least one in four women and one in nine men are victims of intimate partner violence (IPV) (Smith et al., 2017). These rates are even higher, 26% to 61% in the lesbian, gay, bisexual, transgender, and queer community (Smith et al., 2017). In Kentucky alone, intimate partner violence and sexual violence ranges from 11%-38% for men and women, respectfully (Center for Disease Control, 2010).

Screening rates for intimate partner violence in primary care are less than 12% (United States Preventative Services Task Force, 2013). Therefore, the purpose of this project was to gather information on current screening practices for IPV among advanced practice registered nurses in Kentucky. Additionally, this project provided education on how to overcome barriers that exist when screening for IPV in clinical practices.

Background

The term intimate partner violence is used to describe any emotional, sexual, or physical violence by a former or current intimate partner (CDC, 2017). The term intimate partner is used to describe two individuals that are in a close relationship including regular contact, familiarity with one another, continued physical or sexual contact, or are self-described as a couple (CDC, 2017). Intimate partner violence is also referred to as domestic violence. Domestic violence is defined as a pattern of abusive behavior by one intimate partner to control another intimate partner (United States Department of Justice, 2017).

According to current research, IPV occurs in all types of intimate relationships regardless of gender identity or sexual orientation (CDC, 2017). According to the 2010-2012 National Intimate Partner and Sexual Violence Survey ([NISVS], Smith et al., 2017), IPV lifetime prevalence ranges from 26%-61% across genders, races, and sexual orientations.

Epidemiology

Globally, violence against women, including partners and non-partners, is estimated to be about 33.3% (World Health Organization, 2013). In the United States, it is estimated that at least one in four women and one in nine men will become victims of intimate partner violence within their lifetime (Smith et al., 2017). In the United States, statistics estimate that every minute 20 people are physically abused by their intimate partner (National Coalition Against Domestic Violence [NCADV], 2015), and it is also estimated that half of all female homicides are a result of intimate partner violence (Petrosky et al., 2017). The national average of violence against women is estimated to be 33.3% while violence against men is roughly 25% (NCADV, 2015). In Kentucky, it is estimated that 11% of Kentuckian women will be a victim of rape in her lifetime (NCADV, 2015). Additionally, statistics indicate that over a lifetime approximately 38% of females and 31% of males in Kentucky have been assaulted by an intimate partner (CDC, 2010).

IPV does not just occur with heterosexual intimate partners. In the United States, approximately 44% of lesbian women and 61% of bisexual women have experienced intimate partner violence (Smith et al., 2017). Additionally, 26% of gay men and approximately 37% of bisexual men report experiencing intimate partner violence (Smith et al., 2017). Research also suggests that lesbian, gay, bisexual, transgender, and queer [LGBTQ] individuals may experience domestic violence by family members due to their sexual orientation or gender identity (Grant et al., 2011).

Economic Consequence(s)

The cost of IPV for the United States is estimated to approach \$6 billion dollars annually (CDC, 2017). These costs include healthcare costs as well as the individual costs of IPV

including time off work and resources utilized. In addition to economic costs, IPV has been linked to multiple health conditions including but not limited to anxiety, depression, post traumatic stress disorder, gastrointestinal disorders, and neurological disorders (CDC, 2017).

Additional research found that healthcare costs for women that suffer from ongoing abuse are 42 percent higher than their non-abused counterparts (Futures Without Violence, 2010). Another study found the lifetime cost for female victims of IPV to total \$103, 767 while the lifetime cost for male victims of IPV was \$23, 414 (Peterson, et al., 2018). The prevention of IPV could help avoid these substantial costs not only accrued by patients but also accrued by healthcare systems.

Globally, the cost of IPV in various countries ranges from \$1 billion to over \$8 billion annually (Day, McKenna, & Bowlus, 2005). The consequences of IPV range from direct physical injury to long term psychological damage (CDC, 2017).

Clinical Practice Screening

Screening for IPV is an evidence-based solution to identify at risk individuals and providing them with referrals within the community. Currently, IPV screening is a grade B recommendation by the U.S. Preventative Services Task Force [USPSTF] in women of reproductive age (USPSTF, 2013). Until recently, the USPSTF (2013) stated it did not have enough evidence to recommend screening for IPV in primary care, however, they recently updated their recommendation to a grade B screening. Grade B recommendations mean that the USPSTF recommends the service and there is “high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial” (USPSTF, 2018). This means the USPSTF suggests or recommends providers offer this service (USPSTF, 2018).

Screening for IPV in primary care is extremely low, even in women which is estimated to be anywhere from 1.5%-12% (USPSTF, 2013). However, statistics show that IPV is experienced across a lifespan for both men and women regardless of sexual orientation (CDC, 2017). In order to decrease the rates of IPV and increase referrals for services for victims of IPV, providers need to be informed on the appropriate screening tools as well as signs of IPV and be encouraged to implement routine screening in their practice. The USPSTF (2013) offers several screening tools which healthcare providers can utilize when screening patients for IPV in the clinic setting including the HITS screening tool. The HITS screening tool is a 4 question, self-administered screening tool to identify IPV victims with a specificity of approximately 80% and a sensitivity of approximately 75% (Iverson, King, Gerber, Resick, Kimerling, Street, & Vogt, 2015). The other tools suggested by the USPSTF (2013) include: Humiliation, Afraid, Rape, Kick (HARK), Partner Violence Screen (PVS), and Woman Abuse Screening Tool (WAST) with sensitivity ranging from 64% to 87% and specificity from 80% to 95%.

The goal of screening for IPV in primary care is to identify at risk individuals and reduce their potential for exposure to violence (USPSTF, 2013). It is expected that by identifying patients in primary care there will be a decrease in hospital visits related to IPV as well as a decrease in consequences related to IPV. Additionally, potential victims will be identified, discussion can ensue, then they can be equipped with the necessary tools to escape possible victimization.

The research is clear that this screening is often being conducted in women's health clinics especially during pregnancy (The American College of Obstetricians and Gynecologists, 2012). There have been some efforts made to increase screening in the emergency room but interventions have not been focused in primary care (McArthur, 2015). With such a large

percentage of individuals at risk for experiencing IPV, it is essential that IPV should be a routine screening in primary care. Under the Affordable Care Act, IPV screening and counseling is reimbursable for women of childbearing age (Family Violence Prevention and Services Program, 2013).

Through the implementation of screening for IPV in clinical practice, it is expected that provider knowledge and the ability to identify, counsel, and refer victims of IPV to the appropriate resources will increase. Providers who screen may feel more confident when offering counseling to IPV victims. It is also expected that at risk individuals with positive IPV screenings will be informed about the community resources available to them. Over time, the implementation of IPV screening in clinical practices will hopefully lead to IPV screening becoming a routine part of primary healthcare and thus lessening the negative consequences of IPV for patients and society.

Specific Aims

There were two specific aims for this study: (1) Identify barriers to screening for intimate partner violence among advanced registered nurse practitioners in Kentucky and (2) Educate advanced practice registered nurses on ways to overcome the identified barriers.

Theoretical Framework: Health Belief Model

This project utilized the Health Belief Model. This model was developed “in order to understand the failure of people to adopt disease prevention strategies or screening tests for the early detection of disease (LaMorte, 2018).

Perceived Susceptibility

Perceived susceptibility refers to a person’s perception of the risk of acquiring an illness (LaMorte, 2018). Providers may not think their patients are susceptible to IPV, depending on

their area of practice (i.e. private practice versus largely Medicaid populations). Also, patients may not perceive their susceptibility for IPV to be very high or be in denial about their current situations.

Perceived Severity

Perceived severity refers to a person's feelings on the seriousness of contracting an illness including medical and social consequences (LaMorte, 2018). Providers may not screen for IPV because they do not release the severity of sequelae for these victims. Additionally, if patients do not present with physical harms but rather mental health issues including anxiety and depression, providers may not realize that IPV is the underlying issue. Patients may also not realize the severity of IPV if they have always been exposed to emotional and physical trauma in their relationships.

Perceived Benefits

Perceived benefits refers to a person's perception of the effectiveness of available interventions to reduce the treat of disease (LaMorte, 2018). Providers may not be willing to screen their patients if they do not feel screening will benefit them. Prior to the 2013 USPSTF update, there was no sufficient evidence to recommend routine IPV screening. Providers may not be aware of new evidence outlining these benefits. Providers may also not offer services if they do not think their patients will follow through with the interventions. Patients who are victims of IPV may not see interventions as beneficial to them if it requires possible economic struggle, social stress, and questions regarding their safety.

Perceived Barriers

Perceived barriers refers to a person's feeling on the obstacles to performing a recommendation (LaMorte, 2018). Providers may not screen for IPV for many reasons including

time, lack of knowledge of IPV, limited community resources, availability and accuracy of screening tools, (Alvarez et al., 2017) patient gender identity/sexual orientation, and reimbursement. An additional barrier for providers in Kentucky is that IPV in adults is not a required reportable offense (KCADV, 2019). For patients, the barriers can include finances, limited resources, social consequences, and many more.

Cues to Action

Cues to action refers to the stimulus needed to trigger the decision-making process to perform or accept a recommendation (LeMorte, 2018). For providers, these cues can include education on IPV and its severity, increased awareness of IPV, and patients who present specifically to discuss IPV. For patients, these cues may include a provider screening for IPV, increased awareness of IPV, or physical, sexual, or emotional harm from their partners.

Self-efficacy

Self-efficacy refers to the level of a person's confidence in their ability to successfully perform a behavior (LeMorte, 2018). For providers, self-efficacy may improve through increased training and education on how to screen patients for IPV, how to counsel patients with positive screens, and how to refer positive screens to the appropriate services. For patients, self-efficacy can be encouraged through provider empowerment of their patients through interventions such as counseling.

Methods

Design

This project used a descriptive design and electronic survey. The survey was sent to members of the state nurse advanced practice professional organization by the organization's list serve administer.

Population and Sample

The population for this study included all advanced registered nurse practitioners (APRNs) that were subscribed to the list serve at the time the survey was emailed. This includes 2,483 APRNs throughout Kentucky with 727 of that total being students. Specific demographics about the members were not readily available.

Measures

The electronic survey was developed for this study utilizing Qualtrics. The survey was developed based on feedback from providers who were questioned about implementing IPV screening tools into their current practice. These providers offered various reasons for not wanting to include IPV screening into their practice including time and resources. Additionally, questions were gleaned from the IPV screening literature. Increased IPV prevalence rates for the LGBTQ community identified in the literature were also considered when formulating the questions.

Overall, the survey asked 23 questions. The survey included seven demographic questions including age, gender, race, sexual orientation, APRN certification, current practice setting as an APRN, and years practiced as an APRN. Two questions directly addressed provider knowledge of IPV. Three questions discussed prevalence in men, women, and LGBTQ. There were two questions that asked providers directly about screening, if they screened and how they screened. Six barriers to screening were identified in the literature, time, knowledge of IPV, reimbursement, lack of community resources, patient sexual orientation and/or gender identity, and availability and accuracy of screening tools. Providers were asked to rank these barriers using a Likert scale. If providers scored greater than a “2” on a scale of “1-5”, they were

redirected to an education link on that topic. When transferred to the educational link, an additional question was asked that indicated if they believed the education was helpful or not.

The education links used were all resources available on the internet. Information came from the Centers for Disease Control (CDC), the Kentucky Coalition Against Domestic Violence (KCADV), the National Coalition Against Domestic Violence (NCADV), and the National Health Resource Center on Domestic Violence.

Procedures

The principle investigator (PI) obtained permission to utilize the state organization list serve. The electronic survey was sent to members of the state nurse advanced practice professional organization by the organization's list serve administrator. The post included a cover letter and a link to the survey. A reminder email was also sent via the list serve after one week. Data was collected in Qualtrics and transferred to SPSS for analysis utilizing a password protected computer. Human subject's approval was obtained through the university Institutional Review Board.

Data Analysis

SPSS was utilized for data analysis as well as the data analysis tools on Qualtrics. Means, standard deviations, and frequencies were used.

Results

Demographic Characteristics

The number of participants who participated in the survey totaled 42. The *n*'s vary due to missing demographic data since some of the 42 participants chose not to participate when answering certain questions. Of those that answered the age demographic question, 36.4% were between the ages of 40-49. The other participants were ages 30-39, 50-59, or 60-69, or 21.2% of

the total. Only 16 of the 33, or 37.2% of the respondents, answered the race question and they all identified themselves as white. Twenty-nine participants (87.9%) identified themselves as heterosexual while less than 10% identified themselves as LGBTQ. The majority of the respondents (54.5%) practice in primary care and 27.9% are certified as family nurse practitioners (FNP). Approximately 51% of the respondents have practiced as an advanced registered nurse practitioner for 1-9 years. (See Table 1. Demographic Characteristics)

Table 1. Demographic Characteristics

Characteristics	<i>n (%)</i>
Age	
30-39	7 (21.2%)
40-49	12 (36.4%)
50-59	7 (21.2%)
60-69	7 (21.2%)
Gender	
Male	1 (3.0%)
Female	32 (97.0%)
Race	
White	16 (37.2%)
Black or African American	0 (0%)
American Indian or Alaska Native	0 (0%)
Asian	0 (0%)
Native Hawaiian or Pacific Islander	0 (0%)
Other	0 (0%)
Sexual Orientation	
Straight/heterosexual	29 (87.9%)
Gay	0 (0%)
Lesbian	1 (3.0%)
Bisexual	3 (9.1%)
Transsexual	0 (0%)
Queer	0 (0%)
Other	0 (0%)
I do not wish to answer this question	0 (0%)
APRN Certification	
CNS	0 (0%)
FNP	12 (27.9%)
WHNP	1 (2.3%)
CNM	1 (2.3%)
ACNP	1 (2.3%)
PMHNP	0 (0%)

AGNP	1 (2.3%)
PNP	1 (2.3%)
Other	0 (0%)
Current Practice Setting	
Primary Care (Family Practice or Internal Medicine)	18 (54.5%)
Women's Health	2 (6.1%)
Acute Care (Inpatient)	2 (6.1%)
Emergency Room	1 (3.0%)
Midwife	0 (0%)
Psychiatric/Mental Health	2 (4.7%)
Pediatrics	1 (2.3%)
Other	7 (16.3%)
Years Practiced as APRN	
1-9	17 (51.5%)
10-19	5 (15.2%)
20-19	7 (21.2%)
30-39	3 (9.1%)
40+	1 (3.0%)

n's vary due to missing data

Prevalence

Approximately 55% of respondents correctly identified prevalence of IPV in women as being one in four. Approximately 46.5% of the respondents correctly identified prevalence of IPV in men as less than one in four. Since the rates of IPV in the LGBTQ community range from 26% to 61%, respondents correctly identified prevalence as one in four (27.9%) and two in four (48.8%). The *n*'s vary due to missing data. (See Table 2. IPV Prevalence)

Table 2. IPV Prevalence

IPV Gender Prevalence	<i>n</i> (%)
Women	
Less than 1 in 4	5 (11.6%)
1 in 4	24 (55.8%)
2 in 4	10 (23.3%)
3 in 4	3 (7.05)
Greater than 3 in 4	1 (2.3%)
Men	
Less than 1 in 4	20 (46.5%)
1 in 4	18 (41.9%)

2 in 4	4 (9.3%)
3 in 4	1 (2.3%)
Greater than 3 in 4	0 (0%)
LGBTQ	
Less than 1 in 4	4 (9.3%)
1 in 4	12 (27.9%)
2 in 4	21 (48.8%)
3 in 4	4 (9.3%)
Greater than 3 in 4	2 (4.7%)

n's vary due to missing data

Current Knowledge of IPV

There were four knowledge based questions on the survey. The first question asked the respondents to rank their knowledge of IPV and 57.1% reported they have some knowledge of IPV, while 28.6% have a lot of knowledge about IPV. Approximately 58% answered that they do screen for IPV in their practice and 55.6% of those that screen for intimate partner violence indicated they practice in family/internal medicine. The most common screening practice among these providers is asking the question, “Do you feel safe at home?” with nearly forty-four percent of respondents reportedly asking this question. Nearly, 51% of respondents did not know that IPV screening for women of childbearing age is a United States Preventative Services Task Force (USPSTF) level B recommendation. (See Table 3. Current Knowledge of IPV)

Table 3. Current Knowledge of IPV

IPV Knowledge	<i>n</i> (%)
Current Knowledge of IPV	
Very little knowledge	6 (14.3%)
Some knowledge	24 (57.1%)
A lot of knowledge	12 (28.6%)
Current Screening for IPV	
No	14 (32.6%)
Yes	25 (58.1%)
I don't know.	2 (4.7%)
I don't want to answer.	2 (4.7%)
Current Screening Practices	
“Do you feel safe?”	18 (43.9%)
Standardized screening tool	5 (12.2%)
Provider discretion	6 (14.6%)

Do not screen for IPV	12 (29.3%)
USPSTF Recommendation	
Yes	20 (46.5%)
No	22 (51.2%)
I don't want to answer.	1 (2.3%)

n's vary due to missing data

Barriers to Screening for IPV

There were six questions regarding barriers to screening for IPV. The providers were asked to respond using the Likert scale with one being not a barrier at all and five being a specific barrier. The respondents identified time as the greatest barrier with a mean of 3.30 and a standard deviation (SD) of 1.38. The second greatest barrier identified was community resources with a mean of 2.80 and a SD of 1.24. Sexual orientation/gender identity was the least identified barrier with a mean of 1.67 and a SD of 1.36. (See Table 4. Barriers to Screening for IPV)

Table 4. Barriers to Screening for IPV

Barrier	<i>n</i>	<i>Mean (SD)</i>
Time	42	3.3095 (1.38789)
Community Resources	41	2.8049 (1.24939)
Availability and Accuracy of Screening Tools	39	2.6923 (1.34074)
Knowledge of IPV	41	2.5366 (1.22673)
Reimbursement	35	2.2571 (1.55947)
Sexual Orientation/Gender Identity	34	1.6765 (1.36450)

n's vary due to missing data

Post-Education Comfort with Overcoming Barriers to Screening

If the respondents answered two or greater on the Likert scale, they were directed to education for the corresponding barrier. After reviewing education for healthcare providers on how to overcome the barrier of time, 63.2% of providers felt more comfortable on how to overcome time as a barrier. Of those that were directed to education on community resources, 52.6% felt more comfortable overcoming this barrier while 42.1% did not review the education.

Of those were directed to education on the availability and accuracy of screening tools for IPV, 62.5% felt more comfortable overcoming this barrier when screening. After reviewing education on knowledge of IPV, 64.7% of respondents felt more comfortable overcoming this barrier. Of those that reviewed education on reimbursement for healthcare providers, 47.1% stated they feel more comfortable overcoming this barrier while 52.9% did not review the education. Lastly, of those that were directed to education on sexual orientation/gender identity, 40% felt more comfortable discussing IPV with this population while 60% did not review the education. (See Table 5. Post-education Comfort with Overcoming Barriers to Screening)

Table 5. Post-Education Comfort with Overcoming Barriers to Screening

Barrier	<i>n</i> (%)
Time	
I do not feel comfortable.	6 (31.6%)
I feel more comfortable.	12 (63.2%)
I did not review the education.	1 (5.3%)
Community Resources	
I do not feel comfortable.	1 (5.3%)
I feel more comfortable.	10 (52.6%)
I did not review the education.	8 (42.1%)
Availability and Accuracy of Screening Tools	
I do not feel comfortable.	1 (6.3%)
I feel more comfortable.	10 (62.5%)
I did not review the education.	5 (31.3%)
Knowledge of IPV	
I do not feel comfortable.	1 (5.9%)
I feel more comfortable.	11 (64.7%)
I did not review the education.	5 (29.4%)
Reimbursement	
I do not feel comfortable.	0 (0%)
I feel more comfortable.	8 (47.1%)
I did not review the education.	9 (52.9%)
Sexual Orientation/Gender Identity	
I do not feel comfortable.	0 (0%)
I feel more comfortable.	4 (40%)
I did not review the education.	6 (60%)

Discussion

This study was able to gather information on current IPV knowledge and screening practices among advanced registered nurses in Kentucky. This study was successful at identifying barriers to screening for intimate partner violence among advanced registered nurse practitioners in Kentucky and provided education to advanced registered nurse practitioners on ways to overcome the identified barriers.

Time

The greatest barrier to screening for IPV identified by advanced registered nurse practitioners in Kentucky was time. According to the research, the average primary care visit is estimated to be approximately 18 minutes (Pupillo, 2013). With the many screening recommendations by the USPSTF, it can be difficult for providers to address all of them. For instance, the average number of issues addressed per visit ranges from 2.5 to 3.1 and primary care physicians only spend up to one minute on additional concerns outside of the chief complaint (Young et al., 2018). This makes it difficult for providers to address complex issues such as IPV given the constraints on appointment times.

Additionally, the electronic health record (EHR) causes providers to spend less time face to face with patients. In one study, researchers suggested that only 27% of a primary care physicians time was spent in clinical, face-to-face with patients while 49% of their time was spent using the EHR and other desk work (Young et al., 2018). With the push for increased technology in healthcare and the demand for precise medical charting, healthcare providers are experiencing increased stress and decreased job satisfaction (Young et al., 2018). Research suggests that additional screenings add burdens to medical providers which makes IPV screening difficult to incorporate into the workflow (Alvarez et al., 2017). This means IPV screening may take a backseat to other screenings such as high blood pressure and depression screening that

have grade A recommendation by the USPSTF (USPSTF, 2013) and do not require extensive counseling and resource management if positive.

The education resources providers reviewed during the survey were borrowed from Futures Without Violence. The PowerPoint was titled “Is Your Relationship Affecting Your Health? Addressing Intimate Partner Violence in Primary Care Settings.” (National Health Resource Center on Domestic Violence, 2018). This presentation provided evidence for screening, evidence-based interventions for screening, assessing, and referring patients, as well as tips for provider self-care. Additionally, it suggests the use of universal education and assessment when discussing IPV in primary care using either setting specific information, brochure based education, or integrated education. The presentation also suggests, in order to save time, providers can add questions to an intake form by using already validated assessment tools (National Health Resource Center on Domestic Violence, 2018). Since the USPSTF recommends screening for women of childbearing age, 14-46, this can be easily added to annual visit forms or included in questions asked annual on the EHR. Providers may also consider standardizing the screening to include all patients in the clinic to ease the burden of paper intake forms and standardize questions asked in the EHR.

Community Resources

Many providers identified access to community resources as a significant barrier when screening for IPV in their patients. Research suggests that an integrated approach to IPV is ideal (Saletti-Cuesta, Aizenberg, & Ricci-Cabello, 2018); however, if community resources are limited it can be difficult to integrate services these patients may need including housing, mental health services, other healthcare services, and finances. There are only 13 rape crisis centers in Kentucky and 120 counties (Kentucky Association of Sexual Assault Programs (KASAP, 2018).

These rape crisis centers are located in the cities of Louisville, Owensboro, Elizabethtown, Paducah, Hopkinsville, Bowling Green, Somerset, Corbin, Hazard, Prestonberg, Morehead, Ashland, Maysville, Covington, and Lexington (Kentucky Cabinet for Health and Family Services, 2017). Although these centers are located in heavily populated cities within the Commonwealth, many areas are left without rape crisis services unless they are willing to travel.

In addition to limited access to rape crisis centers, the Health Resources and Services Administration (HRSA) recognizes 461 sites throughout Kentucky to be considered health professional shortage areas (HRSA, 2019). These are areas where patients lack access to many healthcare providers and they are dispersed across the state, even in heavily populated cities such as Louisville. These issues make it complicated for patients to seek medical care, be identified as at risk for IPV, and have access to the necessary resources.

For providers who have the luxury of a local rape crisis center, referral may be easy. For those who lack this access, they are encouraged to direct their patients to 24-hour rape crisis hotlines. Unfortunately, there is not adequate literature available on the effectiveness of hotline only counseling services.

For patients who need mental health services, rape crisis centers also have the ability to direct patients to providers who may specialize in counseling those experiencing IPV even if there is no sexual or physical trauma. Many centers have walk-in services where victims can speak with advocates who have specialized training on how to counsel and assist victims of IPV (KCADV, 2018). Providers may also consider referral to mental health professionals, support groups, churches, or other local organizations.

Since Kentucky has such a large number of HRSAs, more services such as crisis centers and mental health services are needed for victims of IPV. Communities that have access to rape

crisis centers should take advantage of sponsored healthcare provider trainings. For those that do not, healthcare providers that recognize a need for IPV services should advocate for increased access to programming in their area. Additionally, statewide resource identification and dissemination could help communities in need.

Availability and Accuracy of Screening Tools

According to the CDC, there are over 20 assessment tools that exist for providers to use when screening for IPV (CDC, 2007). Each of these tools vary in validity and reliability. For these reasons, the USPSTF recommends the use of the following tools based on their accuracy in identifying IPV: The Humiliation, Afraid, Rape, Kick (HARK) tool, the Hurt, Insult, Threaten, Scream (HITS) tool, the Extended-Hurt, Insult, Threaten, Scream (E-HITS) tool, the Partner Violence Screen (PVS), and/or the Women Abuse Screening Tool (WAST) (USPSTF, 2018).

Providers wanting to incorporate screening for IPV should choose the best screening tool for their clinic site. Additionally, the ease of incorporating the screening tool into the EHR or onto intake forms should be considered. A study out of California found that when screening was initiated by a medical assistant, it resulted in more documented screenings than when administered by a physician alone (Sharpless, Nguyen, Singh, & Lin, 2018). If the goal is to increase screening, providers within the same clinic setting should agree on a screening tool to use for their population and a way to implement the tool that would not cause significant burden for providers or other staff members.

Reimbursement

Since prevention is important in reducing costs, providers are encouraged to screen. Based on the results of the survey used for this study, some providers find reimbursement to be a significant barrier to screening for IPV. If patients should have a positive screening or need

counseling, the office visit can quickly exceed the scheduled time interfering with time scheduled for other patients. This has the potential to reduce patient satisfaction rates and reduce profit for the office.

Though screening seems to be costly for healthcare providers, the American College of Obstetricians and Gynecologists (ACOG) (2018) published a Health Care Provider Toolkit that outlined how providers should code visits for IPV. According to the Current Procedural Terminology (CPT), codes 99384-99387 are appropriate for counseling and evaluations for initial office visits and comprehensive preventative medical examinations. If the encounter was for screening for a patient without symptoms, codes 99401-99404 are used based on time spent with the patient. Providers can also use the diagnosis code Z13.89, Encounter for screening for other disorder (ACOG, 2018). These codes exist so providers can bill for services offered. By screening for IPV, providers can be reimbursed and possibly help save thousands of dollars for their patients.

Sexual Orientation/Gender Identity

The vast majority of sexual assault and IPV awareness centers around heterosexual relationships, however, LGBTQ members may experience IPV at higher rates than their heterosexual counterparts (NCADV, 2018). Research also shows us that LGBTQ members are more likely to experience different forms of IPV including intimidation, threatening to reveal their partner's sexual orientation or gender identity, and verbal harassment (NCADV, 2018).

In addition to lack of awareness raised about IPV in LGBTQ communities, these individuals also face additional barriers not experienced by their heterosexual counterparts. They may be afraid of fueling anti-LGBTQ bias, have low levels of confidence in the effectiveness of the legal system, be denied access to rape crisis centers and services, and be

fearful of rejection in their family or community. Research also indicates this population lacks confidence in healthcare providers since there is often a lack of appropriate training regarding the LGBTQ community in general as well as when dealing with IPV (NCADV, 2018).

The National Resource Center on Domestic Violence (NRCDV) offers many training guides, education resources, and recommendations for healthcare providers when addressing IPV in the LGBTQ community (NRCDV, 2019). Some of the recommendations include asking patients what their preferred gender pronoun is, implementing universal screening in clinics so this population is not ignored, and identifying community and online resources for this community (NRCDV, 2019). In order for providers to be comfortable and efficient in discussing social problems and screening for LGBTQ related health issues as well as IPV, providers could attend continued education classes and seek out opportunities to gain information about this community.

Knowledge of IPV

In Kentucky, all registered nurses are required to earn three contact hours of Kentucky Board of Nursing (KBN) approved domestic violence credit hours within three hours of obtaining their licensure into Kentucky (KBN, 2019). For those who received their nursing degree from Kentucky, these hours are built into their undergraduate nursing programs. This is a one-time requirement and continued education credits are not required. Since this education may have been obtained many years ago, this can lead to gaps in knowledge about current IPV screening recommendations, updates to practice, and current statistics in both Kentucky and the United States.

While taking the survey, approximately half of the respondents were not aware the USPSTF recommendation on screening for IPV is a level B recommendation (USPSTF, 2013).

Some of the respondents were also not able to correctly identify prevalence rates in women, men, and LGBTQ members and IPV. Given the wide range of answers on how providers are screening, Kentucky advanced practice registered nurses may not be adequately trained on evidence-based screening interventions for IPV.

The Kentucky Coalition Against Domestic Violence holds an annual conference where all of those involved in caring for victims of IPV gather to educate themselves on services available to victims in Kentucky and learn new information on IPV (KCADV, 2019).

Additionally, 2019's Kentucky Coalition of Nurse Practitioners and Nurse Midwives does not have any sessions specifically addressing IPV but does include a session on Human Trafficking (KCNPNM, 2019). While this information is useful for healthcare providers, specific information and training on how to screen, counsel, and refer IPV victims is needed in Kentucky. The development of specific continued education credits for advanced registered nurse practitioners could help fill the information gap and encourage more providers to screen.

Limitations

There were several limitations to this study including small sample size, limited survey questions, and time consuming education. Suggestions for how to overcome these limitations is included in future research.

Sample Size

The sample only included 42 of 2,483 members of a state organization for advanced practice registered nurses. Also, the majority of the respondents to the survey were white, middle-aged, females. Since the organization's demographics are not readily available, it is unknown if the sample population is a good representation of the organization.

Limited Survey Questions

The survey did not include questions that addressed urban versus rural areas of practice which could impact the provider's views on community resources available. Additionally, the survey did not address whether providers have any relevant personal experience with IPV. This could strongly influence which providers chose to participate in the survey, the rate of screening, and their willingness to overcome barriers in order to screen for IPV.

Time Consuming Education

Since the education was borrowed from current national and state organization websites, some of the information was difficult to maneuver around. Since providers identified time as a barrier to screening for IPV, time could have also been a barrier for these providers when viewing the education. This could account for those who chose "did not review the education" as a response.

Implications for Current Practice

Increase Awareness

In order to encourage prevention efforts against IPV, there needs to be increased societal awareness of IPV. Currently, April is Sexual Violence Awareness month and many organizations promote activities in April in order to increase awareness within communities. Additionally, national media promotes ideas such as #metoo which encourages victims of sexual violence to share their stories in solidarity. Though these efforts exist, it is still not enough. More communities need to encourage the idea to end violence, in all forms, not just IPV. Efforts including local rallies, survivor walks and campaigns, and nurse led initiatives to prevent IPV should all be encouraged.

Provider Education

This survey was able to show that when providers have access to education, they can become more comfortable in overcoming barriers to screening for IPV in practice. Additionally, they may be more willing to implement IPV screening in their practice if given adequate education and training. In order to accomplish this, continued education credits about IPV need to be developed for advanced practice registered nurses. In the same way Kentucky requires undergraduate nursing students to obtain domestic violence contact hours, adding contact hours about IPV to graduate curriculum should be considered. This would ensure that future advanced nurses have the education needed to be successful in discussing IPV with their patients and provide appropriate counseling.

Primary Prevention

Although this project focused primarily on secondary prevention of IPV, it revealed a great need for primary prevention efforts. While screening for IPV in healthcare settings may provide an opportunity for interventions in current victims, efforts should be made to prevent IPV from occurring. Implementing healthy relationship and sexual education into school systems and into well child exams can help increase awareness of IPV in young students and patients while promoting the formation of relationships that do not involve violence.

Conclusion

Overall, more research needs to be conducted on screening for IPV and APRNs. Additionally, more education is needed for health care providers to be able to screen, assess, diagnose, and treat or refer victims of IPV. Finally, universal screening should be promoted and adopted by clinics and providers in order to ensure all genders and sexual orientations are being screened for intimate partner violence.

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